Louisiana Impact Estimate of Federal Health Care Reform 2010

Louisiana Department of Health and Hospitals
Secretary Alan Levine

Summary of The Act

- The Patient Protection and Affordable Care Act of 2010 (PPACA)
  - Requires most U.S. citizens and legal residents to have health insurance;
  - Expands Medicaid to 133% of federal poverty level (FPL) - with disregard, to 138% of FPL; and
  - Creates state Health Insurance Exchanges through which individuals and small employers can purchase coverage, with premium and cost sharing tax credits available to individuals and families with income between 133 and 400% of the FPL.

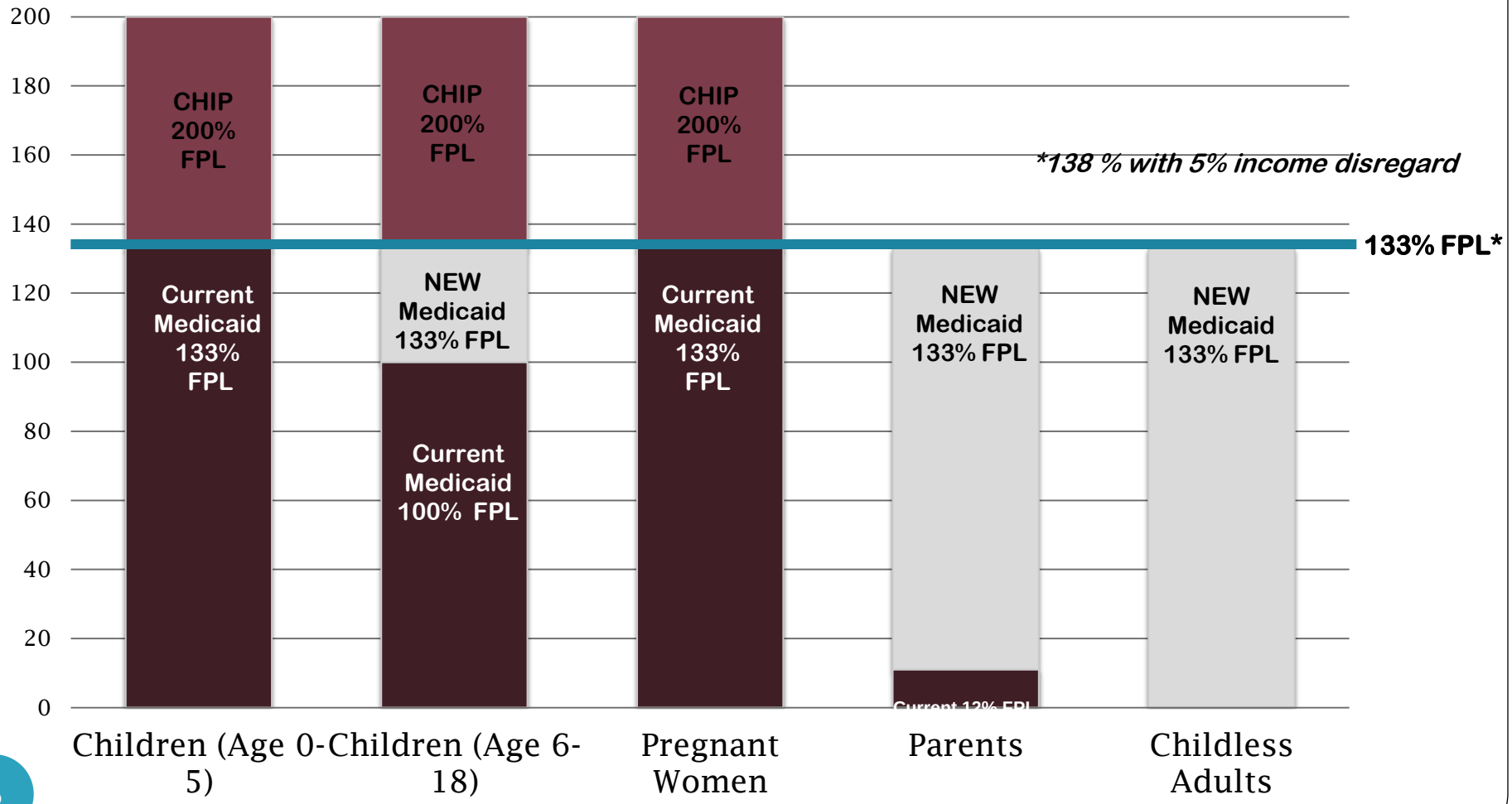
Maintenance of Effort Provisions

- The provision is nearly identical to the American Reinvestment and Recovery Act (ARRA), and the state anticipates the same broad interpretation.
- The restrictions are measured against standards, methodologies and procedures in place as of March 23, 2010.
- ARRA provided an enhanced match rate during the MOE time-period. However, it does not apply between January 1, 2011 and December 31, 2013, leaving states to cover the deficit until 2014.
  - Existing Medicaid eligibility until the Exchange is fully operational; and
  - Existing CHIP eligibility to 2019 *(funding provided through FFY 2015).
- The penalty for any eligibility rollback is loss of ALL federal funding for the State's Medicaid and CHIP programs - not just the enhanced rate in ARRA.

Significant expansion of Medicaid

- Eligibility Effective 1/1/2014
  - Adults and children with incomes up to 138% of the FPL
- Currently, the following groups are eligible:
  - Parents eligible to 11% FPL;
  - Childless adults ineligible at any income; and
  - Children ages 6-18 between 101% and 133% FPL eligible for CHIP.

Current and Future (1/1/14) Medicaid/LaCHIP Eligibility

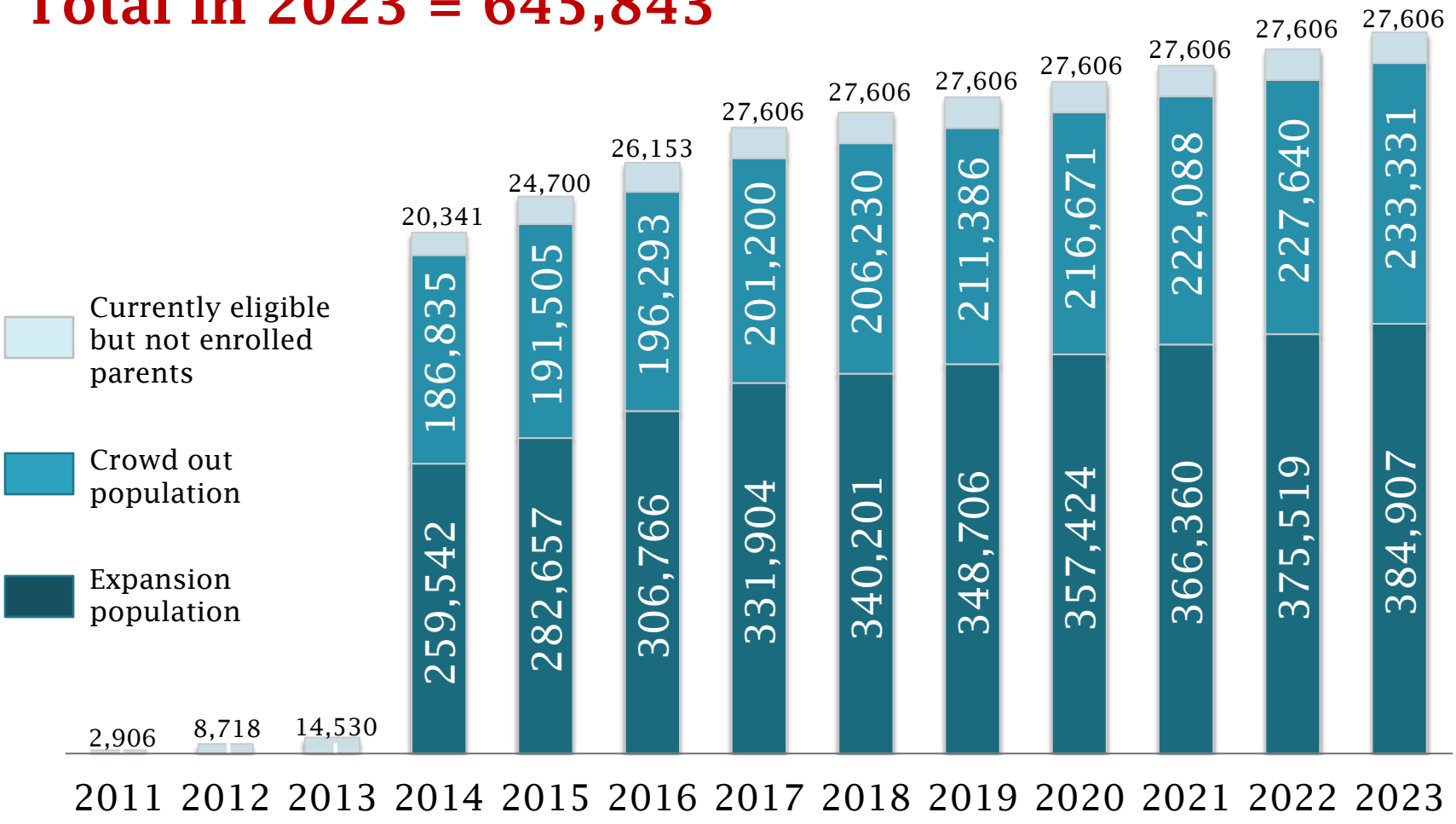


New Rules for Medicaid Eligibility

- **Beginning 2014**
  - Standard calculation across states; and
  - Use modified adjusted gross income (MAGI) as defined for federal income tax purposes (line 37 of the IRS 1040) with 5% income disregard and no asset test.
  - 5% disregard effectively increases income limit to 138% FPL
- **Now**
  - Calculations vary by state; and
  - Louisiana uses gross income with disregards for child care (up to $200/child/month), child support (first $50/month) and earned income ($90/parent/month) and no asset test.
  - Disregards effectively increase income eligibility limits, effective income limits vary by circumstance

Estimated Enrollment Impact SFY2011-23

Total in 2023 = 645,843



Total SGF exposure could top $7 billion over 10 years from implementation

	Enrollees	StateGeneral Funds
Newly eligible uninsured parents and childless adults	384,907	$ 1,793,642,511
Newly eligible adults and children who drop private coverage	233,331	$ 1,203,104,525
Parents currently eligible for Medicaid but not enrolled	27,606	$ 701,750,473
Medicaid administration		$ 200,096,871
Physician fee increases		$ 464,648,760
Physician utilization increase		$ 187,094,278
Medicaid FMAP for children 101-133% FPL now in CHIP	45,879	$ 291,504,044
Community Mental Health Centers		$ 488,488,269
Hospital rate increase		$ 1,557,941,567
Hospital utilization increase		$ 280,429,482
TOTAL STATE COST IMPACT		**$ 7,168,700,779**

Why So Much?

- ***Required*** expansion will add to the Medicaid rolls
  - Not only uninsured adults
  - But also currently eligible but unenrolled parents
  - As well as childless adults, parents and children who drop private coverage

Total Enrollment Will Grow by More Than 50%

- 1.1 million enrollees now + 645K from expansion
- Take up rate assumptions vary by population
  - Uninsured childless adults and parents
    - 80% of total will enroll in 2014, 85% in 2015, 90% in 2016, 95% in 2017 and after
    - Cost to state: $ 1,793,642,511
  - Currently eligible but unenrolled parents
    - 10% of total will enroll in 2011, 30% in 2012, 50% in 2013, 70% in 2014, 85% in 2015, 90% in 2016 and 95% in 2017 and after
    - Cost to state: $ 701,750,473
  - Insured childless adults, parents and children who drop private coverage
    - 80% will enroll in 2014 and after
    - Cost to state: $ 1,203,104,525

Cost Per Person leans high due to adult population being added

- Per person costs developed by contracted Mercer actuaries
- Based on actual Louisiana Medicaid claims data, adjusted by age, sex, parenthood status
- Range of per person costs provided
  - High – $490 per adult per month (total for ages 19-64)
  - Middle – $406 per adult per month
  - Low – $321 per adult per month

State Cost Per Person Depends on FMAP

- **Federal matching funds rate vary by population**
  - The lower the FMAP the higher the SGF cost and vice versa
- **Newly eligible uninsured (lowest SGF per person)**
  - 100% FMAP for expansion population at start up, phases down beginning in 2017 to 90% by 2020
    - (100% 2014-2016; 95% 2017; 94% 2018; 93% 2019; 90% 2020 and beyond)
- **Newly eligible who drop private coverage**
  - Adults eligible for expansion FMAP (90-100%), children eligible for CHIP (~75%) or Medicaid (~67%) FMAP depending on age and income
- **Currently eligible parents (highest SGF per person)**
  - Eligible for Medicaid FMAP (~67%)

Loss of CHIP FMAP for Children 101-133% FPL

- By expanding Medicaid to 133% FPL for all ages, PPACA requires States move to Medicaid in 2014 children ages 6-18 with incomes between 101-133% FPL who are now eligible for CHIP

- With the move, the children will get Medicaid FMAP (~67%) instead of CHIP FMAP (~75%)

  - Only adults qualify for the expansion FMAP (90-100%)

- *States will have to make up the difference in the total cost*

New Definition of Medical Assistance

- The term “medical assistance” refers to the care and services provided under Medicaid, in addition to service payment.

- This section changes, for the first time in 40 years, the definition of "medical assistance" from simply paying for services to also include "provision of services, which could change how courts view past precedent.“

  - This creates an unknown in the Medicaid program as far as future costs and predictability in expenditures is concerned.

Primary Care Physician Fee Increase

- Reform provides for two-year increase to primary care provider rates to 100% of Medicare
- The increase is not funded after two years
- State must either pay cost to continue fee increase or make major cut to providers.
- Cost to state: $237 million SGF for existing and expansion populations

Specialty Care Physician Fee Increases

- Primary care fee increases without addressing specialists will leave primary care providers with greater responsibility and little support.
- Increasing volumes of patients will burden these providers, particularly if they have nowhere to refer patients with specialized needs.
- We assume increases in physician fees for specialty services to 100 and 110% of Medicare to meet demand
  - Cost impact to 100% of Medicare
    - $158 million SGF for existing and expansion populations
  - Cost impact from 100% to 110% of Medicare
    - $68 million SGF for existing and expansion populations

Hospital Rate Increases

- The health care system as a whole is financed by a mix of public and private payer sources
- Public programs tend to pay providers below the cost of service and private payers at or above cost
- With 26% of Louisiana's population on Medicaid, providers have found ways to offset these lower payments. However, if volumes increase to 40%+ Medicaid, the state cannot continue to pay below cost. CMS already states with the cuts in the bill, 15% of hospitals could close. This would exacerbate the problem.
- The result may be an increase in uncompensated cost for hospital services provided to Medicaid enrollees
- *We assume that Medicaid rates for inpatient and outpatient hospital services will have to increase to at least 90% of cost to keep these institutions solvent as the payer mix shifts*
- *Cost to state:* $1.5 billion SGF for the existing Medicaid population

Utilization Increases

- Service utilization is expected to increase for multiple reasons
- Childless adults are known to have higher medical costs as a result of mental health/substance abuse related issues
- Increased provider rates = increased utilization.
- Cost impact
  - $187 million SGF for primary care and specialty physician services provided to existing and expansion Medicaid populations
  - $280 million SGF for inpatient and outpatient hospital services for the existing population

Increased Administrative Costs

- FMAP assumed at 50% for all year
- Costs associated with eligibility determination for expansion population, customer service, claims payment, enrollment broker
  - Approximately 289 additional eligibility staff needed
- Major IT system costs
  - Replacement of antiquated, "green screen," mainframe eligibility system to meet expansion requirements
  - Changes to claims payment system
  - Interoperability with Health Exchange
- *Expansion will increase SGF cost beginning in SFY 12*
- Cost impact to state: $200 million SGF

We will still have up to 300,000 uninsured

- Some will still not be insured:
  - Undocumented immigrants;
  - People who have religious objections;
  - People for whom coverage is unaffordable;
  - People between coverage for less than three months; and
  - People who choose not to have insurance and pay the penalties instead.
- DSH does not just pay for uninsured – To the extent Medicaid pays hospitals below cost, DSH would still be needed for underpayments.

DSH reductions and Uncompensated Care

- Uncompensated cost comes from the following services:
  - Those provided to the uninsured;
  - Those provided to the under-insured; and
  - Those provided to Medicaid/CHIP enrollees that are not fully reimbursed by Medicaid rates.
- State's DSH allotment will be reduced, beginning in FFY 2014.
- DSH payments for hospital-based uncompensated care costs will be reduced.
- Cannot accurately estimate DSH reductions at this time – subject entirely to rules to be determined by HHS.

Accountable Care Organizations And Payment Reform

- The reform bill provides authority for the Secretary to implement various payment and system changes to public programs.
- Accountable Care Organizations (ACO) are one such initiative. ACOs are effectively Coordinated Care Networks as we have defined them in our own state's reforms.
- Goal of ACOs is to improve care coordination, efficiency, quality and patient satisfaction — largely by keeping patients out of acute- and intensive-care settings using preventive health measures, while simultaneously shifting reimbursements so that they are based on the achievement of performance goals.
- With the expansion of Medicaid, it will be essential to implement the CCN model, which is both encouraged in the reform bill, and will be necessary to help contain cost growth and improve quality in the future.

State Health Insurance Exchange

- Establishment of the Exchanges will involve state agencies, such as the Department of Insurance (DOI) and Louisiana Medicaid.
- If a State does not develop a qualifying implementation plan, the Secretary of HHS must establish the Exchange.
- An Exchange must be a State government agency or a non-profit entity established by the State.
- A state may contract with an "eligible entity" to carry out one or more responsibilities of the Exchange.
- An eligible entity is either the State Medicaid agency or a person incorporated under the laws of a state who is not a health insurance issuer, but has demonstrated experience in the individual and small group health insurance markets.

Exchange Functions & Responsibilities

- Market qualifying health plans, which must include federally-determined "essential health benefits" as approved by the HHS Secretary, to be marketed on the Exchange;
- Establish an application process for Medicaid/Chip and insurance purposes;
- Develop processes for the dissemination of information to the public, such as a website or call center for assistance;
- Administer federal subsidies for the purchase of health insurance;
- Establish electronic interfaces to facilitate eligibility and subsidy determinations;
- Coordinate with the State Medicaid Program; and
- Assess fees to cover the cost of the administration of the Exchange.

Exchange Timeline

- If Louisiana opts to establish an exchange, the State must obtain federal approval of the implementation plan by January 1, 2013.
- Exchanges must be functional by January 1, 2014, facilitate the purchase of qualified health plans, and assist qualified employers in the small group market.
- Exchanges must be financially self-sustaining by January 1, 2015.
- Beginning in 2017, states may allow issuers of health insurance coverage in the large group market to offer qualified health plans through an Exchange.
- By March 2011, HHS will make awards to states for the establishment of the Exchanges; grants may be renewed through December 31, 2014, but cannot be used for ongoing operations after January 1, 2015.

Impact to the State High Risk Pool

- PPACA calls for July 1, 2010 implementation of high risk pools for individuals with pre-existing conditions in every state under strict federal guidelines.

- By correspondence to HHS dated 4/28/2010, Louisiana has chosen to opt-out of applying to operate a high risk pool for the following reasons:

  - Louisiana already operates a state-based high risk pool;

  - State's concern is based in part on the fact that, historically, other "partnerships" with the federal government become short-funded, often leaving the state with few options – among them, end programs or increase SGF. TheAdministration's CMS actuaries say the reform bill short-funds the high risk pools. Knowing this, we could not recommend the state take this risk, particularly since we already have a pool.

  - At this time, there are no definitive answers as to how the funding stream will be implemented and sustained for the new pools. No rules or policies in place

  - The state should be prepared for impact to people in the state's current high risk pool. There will be different policies affecting people who will have no option to join the new pool.

Provisions related to Long Term Care

- All provisions, with exception of Spousal Impoverishment rules, are optional rather than mandatory.
- Louisiana has already applies Spousal Impoverishment rules so there is no impact.
- Optional provisions offer increased federal match for greater use of Home and Community Based Services, but potential impact for Louisiana can't be assessed without further clarification/guidance from CMS on the following items:
  - Changes to Section 1915(i) State Plan Option;
  - Community Choice Option;
  - HCBS Rebalancing Incentives;
  - Money Follows the Person; and
  - Spousal Impoverishment Rules.

Federal Tax Changes & Penalties
Provisions affecting employers

- Tax Credits for small employers (25 or less employees and average annual salary <$50,000).
- Penalties for large employers (50+ full time equivalents) that have at least one employee receiving a subsidy in the exchange even if employer offers coverage.
  - Higher penalties for not providing coverage
  - Any firm that has a combination of full and part-time regular non seasonal employees that work an aggregate of 1500 hours per week would be considered a large employer.
    - Simple example: a firm that has no full time employees, but has 100 part-time employees that each work 15 hours a week would be considered a “large employee”.
- Exempts employers with fewer than 50 FTEs from any of the above penalties.

Federal Tax Changes & Penalties
Provisions affecting employers (continued)

- Excise tax on high-cost employer-sponsored health insurance;
- Annual fee on health insurance providers;
- Annual fee on manufacturers and importers of brand name pharmaceuticals; and
- Excise tax on manufacturers and importers of certain medical devices.

Federal Tax Changes & Penalties
Provisions affecting individuals

- Tax credits for families earning between 133% and 400% FPL that will effectively cap the cost of health insurance premiums between 2 and 9.5% of adjusted gross income (AGI);
- Penalty on those who choose not to have health insurance of $695 or 2.5 percent of income, whichever is higher;
- Additional Medicare Payroll Tax of 0.9% (to 3.8%) on workers with wages over $200,000 for single filers and $250,000 for joint filers;
- Extension of the Medicare tax of 3.8% to net investment income;
- Modifications to Tax-Advantaged Accounts such as FSAs, HSAs, and HRAs. (Contribution limits, increased penalties for nonqualified use, restricted definition of qualified medical expenses); and
- Increases the threshold for the amount that taxpayers can deduct unreimbursed medical expenses to expenses that exceed 10% of AGI (from 7.5%).

Critical and Time Sensitive Issues

- Prescription drug rebate - retroactive to 1/1/2010
  - Increases the minimum rebate percentage for name and generic drugs, which has a negative impact on the state;
  - The increases go solely to the federal government with a reduction of payments to the State; and
  - Payment reduction "shall be deemed an overpayment" that will be disallowed against the State; and
  - **Is "not subject to reconsideration" before the Departmental Appeals Board.**
  - To date in SFY 10, the State has collected about $43 million in supplemental rebates.
  - An analysis by Provider Synergies, projects the for the current fiscal year the State faces a 27% reduction in supplemental rebate revenues, **amounting to an estimated loss of $11M for a full fiscal year. Resulting in a loss of $5.5 million the current fiscal year.**
  - States are still waiting on rebate computation decisions.
- Health care acquired conditions – effective 7/1/2011
  - Medicaid will not make payments for health care acquired conditions; and
  - Methodology must be determined to bridge between current per diem reimbursement and DRG Medicare uses.

Grant Opportunities

- Community Transformation
  - Creates a grant program to assist State agencies and other entities implement, evaluate and disseminate evidenced-based community preventive health activities.
- Health Care Workforce
  - State workforce development grants for which Louisiana Workforce Commission would be state agency lead; and
  - Health professionals workforce demonstration projects to address workforce needs.

Questions